COMMONWEALTH of VIRGINIA
Department of Veterans Services

C. L. "Bert" Boyd
Chief Deputy Commissioner

Poff Federal Building
270 Franklin Road, S. W.
Roanoke, Virginia 24011-2215

Telephone (540) 857-7101
Fax (540) 857-7573

Virginia War Orphans Education Program
Application to Determine Eligibility

Applicant Information

Name _____ SSN _____
Last First Middle

Address _____

City _____ State _____ Zip _____

Place of Birth _____ Date of Birth _____

School Last Attended _____ Year Completed _____

Name of Parent or Guardian _____

Address _____

City _____ State _____ Zip _____

Applicant Telephone _____ Parent/Guardian Telephone _____

Military Service Information

Name of Veteran _____
Last First Middle

Branch of Service USA ☐ USN ☐ USMC ☐ USAF ☐ USCG ☐

Dates of Active Duty Service _____ to _____

Service Number _____ SSN _____ VA Claim Number _____

Date and cause of veteran's death or permanent and total disability – please be specific:

_____

_____

_____

_____

Residency and Other Information

Was the veteran a citizen and legal resident of Virginia upon entering service: Yes ☐ No ☐

Was the veteran a citizen and legal resident of Virginia for five (5) consecutive years prior to the date of this application or prior to his or her death? Yes ☐ No ☐

Was the surviving parent a citizen and legal resident of Virginia for five (5) years prior to marrying the veteran; or a citizen and legal resident of Virginia for (5) consecutive years prior to the date of this application? Yes ☐ No ☐

List the names and birthdates of any brothers and/or sisters who have attended college under the Virginia War Orphans Education Program:

_____ _____

_____ _____

Applicant will attend the following college or university:

_____

Name of College or University City and State Begin Date

I certify that the information contained in this application is true and correct to the best of my knowledge.

_____ _____

Signature of Applicant Date

FOR OFFICE USE ONLY

Death Yes ☐ No ☐ **PT (WTS)** Yes ☐ No ☐ **POW/MIA** Yes ☐ No ☐

Age Yes ☐ No ☐ **Residency** Yes ☐ No ☐ **Eligible** Yes ☐ No ☐

If eligible, why? _____

_____

_____

Claims Examiner _____ Date _____

Claims Examiner _____ Date _____